

**UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF GEORGIA
Atlanta Division**

EMMA KOE, et al.,

Plaintiffs,

v.

Case No. _____

CAYLEE NOGGLE, et al.,

Defendants.

DECLARATION OF DANIEL SHUMER, M.D.

I, Daniel Shumer, M.D., hereby declare and state as follows:

1. I have been retained by counsel for Plaintiffs as an expert in connection with the above-captioned litigation.
2. I have actual knowledge of the matters stated herein. If called to testify in this matter, I would testify truthfully and based on my expert opinion.

I. BACKGROUND AND QUALIFICATIONS

A. Qualifications

3. I am a Pediatric Endocrinologist, Associate Professor of Pediatrics, and the Clinical Director of the Child and Adolescent Gender Clinic at Mott Children's Hospital at Michigan Medicine. I am also the Medical Director of the Comprehensive Gender Services Program at Michigan Medicine, University of Michigan.

4. I am Board Certified in Pediatrics and Pediatric Endocrinology by the American Board of Pediatrics and licensed to practice medicine in the state of Michigan.

5. I received my medical degree from Northwestern University in 2008. After completing a Residency in Pediatrics at Vermont Children's Hospital, I began a Fellowship in Pediatric Endocrinology at Harvard University's Boston Children's Hospital. Concurrent with the Fellowship, I completed a Master of Public Health from Harvard's T.H. Chan School of Public Health. I completed both the Fellowship and the MPH degree in 2015.

6. I have extensive experience in working with and treating children and adolescents with endocrine conditions including differences in sex development (DSD) (also referred to as intersex conditions), gender dysphoria, type 1 diabetes, thyroid disorders, growth problems, and delayed or precocious puberty. I have been treating patients with gender dysphoria since 2015.

7. A major focus of my clinical, teaching, and research work pertains to the assessment and management of transgender adolescents.

8. I have published extensively on the topic of gender identity in pediatrics and the treatment of gender dysphoria, as well as reviewed the peer-reviewed literature concerning medical treatments for gender dysphoria, the current standards of care for the treatment of gender dysphoria, and research articles on a variety of topics with a

focus on mental health in transgender adolescents.

9. I am involved in the education of medical trainees. I have previously been the Fellowship Director in the Division of Pediatric Endocrinology, and am currently the Education Lead for the Division of Pediatric Endocrinology, and Course Director for a medical student elective in Transgender Medicine. My additional academic duties as an Associate Professor include teaching several lectures, including those entitled “Puberty,” “Transgender Medicine,” and “Pediatric Growth and Development.”

10. As a Fellow at Harvard, I was mentored by Dr. Norman Spack. Dr. Spack established the Gender Management Services Clinic (GeMS) at Boston Children’s Hospital. While working and training at GeMS, I became a clinical expert in the field of transgender medicine within Pediatric Endocrinology and began conducting research on gender identity, gender dysphoria, and the evaluation and management of gender dysphoria in children and adolescents.

11. Based on my work at GeMS, I was recruited to establish a similar program assessing and treating gender diverse and transgender children and adolescents at the C.S. Mott Children’s Hospital in Ann Arbor. In October 2015, I founded the hospital’s Child and Adolescent Gender Services Clinic.

12. The Child and Adolescent Gender Services Clinic has treated over 600 patients since its founding. The clinic provides comprehensive assessment and, when

appropriate, treatment with pubertal suppression and hormonal therapies, to patients diagnosed with gender dysphoria. I have personally evaluated and treated over 400 patients with gender dysphoria. The majority of the patients receiving care range between 10 and 21 years old. Most patients attending the clinic live in Michigan or Ohio. As the Clinical Director, I oversee the clinical practice, which currently includes 4 physicians (including 1 psychiatrist), 1 nurse practitioner, 2 social workers, 1 research coordinator, as well as nursing and administrative staff. I also actively conduct research related to transgender medicine, gender dysphoria treatment, and mental health concerns specific to transgender youth.

13. I also provide care in the Differences/Disorders of Sex Development (DSD) Clinic at Michigan Medicine at Mott Children's Hospital. The DSD Clinic is a multidisciplinary clinic focused on providing care to infants and children with differences in the typical path of sex development, which may be influenced by the arrangement of sex chromosomes, the functioning of our gonads (i.e., testes, ovaries), and our bodies' response to hormones. The clinic is comprised of members from Pediatric Endocrinology, Genetics, Psychology, Urology, Gynecology, Surgery, and Social Work. In this clinic I have assessed and treated over 100 patients with DSD. In my role as Medical Director of the Comprehensive Gender Services Program (CGSP), I lead Michigan Medicine's broader efforts related to transgender services. CGSP is comprised of providers from across the health system including pediatric care, adult

hormone provision, gynecologic services, adult surgical services, speech/language therapy, mental health services, and primary care. I run monthly meetings with representatives from these areas to help coordinate communication between Departments. I coordinate strategic planning aimed to improve care within the health system related to our transgender population. I also serve as the medical representative for CGSP in discussions with health system administrators and outside entities.

14. I have authored numerous peer-reviewed articles related to treatment of transgender youth. I have also co-authored chapters of medical textbooks related to medical management of transgender patients. I have been invited to speak at numerous hospitals, clinics, and conferences on topics related to clinical care and standards for treating transgender children and youth.

15. The information provided regarding my professional background, experiences, publications, and presentations is detailed in my curriculum vitae, a true and correct copy of the most up-to-date version of which is attached as **Exhibit A**.

B. Prior Testimony

16. In the past four years, I have been retained as an expert and provided testimony at trial or by deposition in the following cases: *Roe et al v. Utah High School Activities Association et al* (Third District Court in and for Salt Lake County, UT); *Menefee v. City of Huntsville Bd. of Educ.*, No. 5:18-cv-01481 (N.D. Ala.); *Dekker v. Weida*, No. 4:22-cv-00325-RH-MAF (N.D. Fla.); *K.C. v. Indiana*, No. 1:23-CV-595

(S.D. Ind.). I also provided expert witness testimony on behalf of a parent in a custody dispute involving a transgender child in the following case: *In the Interest of Younger*, No. DF-15-09887 (Dallas County, Texas). I have also been retained as an expert witness in *Boe v. Marshall*, No. 2:22-cv-00184-LCB-SRW (M.D. Ala.), and *Doe v. Ladapo*, No. 4:23-cv-114-RH-MAF (N.D. Fla.).

C. Compensation

17. I am being compensated at an hourly rate for the actual time that I devote to this case, at the rate of \$350 per hour for any review of records, preparation of reports, declarations, and deposition and trial testimony. My compensation does not depend on the outcome of this litigation, the opinions that I express, or the testimony that I provide.

D. Bases for Opinions

18. In preparing this declaration, I reviewed the text of Senate Bill 140 titled “Hospitals; the treatment of gender dysphoria in minors performed in hospitals and other licensed healthcare facilities . . .” passed into law in 2023.

19. I have also reviewed the materials listed in the bibliography attached as **Exhibit B** to this report, as well as the materials listed within my curriculum vitae, which is attached as **Exhibit A**. The sources cited therein include authoritative, scientific peer-reviewed publications. They include the documents specifically cited as supportive examples in particular sections of this report. I may rely on these materials

as additional support for my opinions.

20. In addition, I have relied on my scientific education, training, and years of clinical and research experience, and my knowledge of the scientific literature in the pertinent fields.

21. The materials I have relied upon in preparing this report are the same types of materials that experts in my field of study regularly rely upon when forming opinions on these subjects.

22. To the best of my knowledge, I have not met or spoken with the Plaintiffs. My opinions are based solely on my extensive background and experience treating transgender patients.

23. I may wish to supplement or revise these opinions or the bases for them due to new scientific research or publications or in response to statements and issues that may arise in my area of expertise.

II. EXPERT OPINIONS

A. MEDICAL AND SCIENTIFIC BACKGROUND ON SEX AND GENDER IDENTITY

24. *Sex* is comprised of several components, including, among others, internal reproductive organs, external genitalia, chromosomes, hormones, gender identity, and secondary sex characteristics (Institute of Medicine (IOM), 2011).

25. *Gender identity* is the medical term for a person's internal, innate sense of belonging to a particular sex. Everyone has a gender identity. Diversity of gender

identity and incongruence between assigned sex at birth and gender identity are naturally occurring sources of human biological diversity (IOM, 2011). The term *transgender* refers to individuals whose gender identity does not align with their sex assigned at birth (Shumer, et al., 2013).

26. The terms *gender role* and *gender identity* refer to different things. *Gender roles* are behaviors, attitudes, and personality traits that a particular society considers masculine or feminine, or associates with male or female social roles. For example, the convention that girls wear pink and have longer hair, or that boys wear blue and have shorter hair, are socially constructed gender roles from a particular culture and historical period. By contrast, *gender identity* does not refer to socially contingent behaviors, attitudes, or personality traits. It is an internal and largely biological phenomenon, as reviewed below. Living consistent with one's gender identity is critical to the health and well-being of any person, including transgender people (Hidalgo, et al., 2013; Shumer, et al., 2013; White Hughto, et al., 2015).

27. A person's understanding of their gender identity may evolve over time in the natural course of their life, however, attempts to "cure" transgender individuals by forcing their gender identity into alignment with their birth sex has been found to be both harmful and ineffective. In one study, transgender adults who recall previous attempts from healthcare professionals to alter their gender identity reported an increase in lifetime suicide attempts and higher rates of severe psychological distress in the

present (Turban, et al., 2020a). In another study, exposure to these types of attempts were found to increase the likelihood that a transgender adolescent will attempt suicide by 55% and more than double the risk for running away from home (Campbell, et al., 2002). Those practices have been denounced as unethical by all major professional associations of medical and mental health professionals, such as the American Medical Association, the American Academy of Pediatrics, the American Psychiatric Association, and the American Psychological Association, among others (Fish, et al., 2022).

28. Scientific research and medical literature across disciplines demonstrates that gender identity, like other components of sex, has a strong biological foundation. For example, there are numerous studies detailing the similarities in the brain structures of transgender and non-transgender people with the same gender identity (Luders, et al., 2009; Rametti, et al., 2011; Berglund, et al., 2008). In one such study, the volume of the bed nucleus of the *stria terminalis* (a collection of cells in the central brain) in transgender women was equivalent to the volume found in non-transgender women (Chung, et al., 2002).

29. There are also studies highlighting the genetic components of gender identity. Twin studies are a helpful way to understand genetic influences on human diversity. Identical twins share the same DNA, while fraternal twins share roughly 50% of the same DNA, however both types of twins share the same environment.

Therefore, studies comparing differences between identical and fraternal twin pairs can help isolate the genetic contribution of human characteristics. Twin studies have shown that if an identical twin is transgender, the other twin is much more likely to be transgender compared to fraternal twins, a finding which points to genetic underpinnings to gender identity development (Heylens, et al., 2012).

30. There is also ongoing research on how differences in fetal exposures to hormones may influence gender identity. This influence can be examined by studying a medical condition called congenital adrenal hyperplasia. Female fetuses affected by congenital adrenal hyperplasia produce much higher levels of testosterone compared to fetuses without the condition. While most females with congenital adrenal hyperplasia have a female gender identity in adulthood, the percentage of those with gender dysphoria is higher than that of the general population. This suggests that fetal hormone exposures contribute to the later development of gender identity (Dessens, et al, 2005).

31. There has also been research examining specific genetic differences that appear associated with gender identity formation (Rosenthal, 2014). For example, one study examining differences in the estrogen receptor gene among transgender women and non-transgender male controls found that the transgender individuals were more likely to have a genetic difference in this gene (Henningsson, et al., 2005).

32. The above studies are representative examples of scientific research

demonstrating biological influences on gender identity. Gender identity, like other complex human characteristics, is rooted in biology with important contributions from neuroanatomic, genetic and hormonal variation (Roselli, 2018).

B. RATIONALE FOR MEDICAL TREATMENT OF GENDER DYSPHORIA IN ADOLESCENTS

33. All medical interventions, including treatment for gender dysphoria, require rigorous study and must be evidence-based.

34. There are several studies demonstrating positive results of gender-affirming care in adolescents (de Vries, et al., 2014; de Vries, et al., 2011; Green, et al., 2022; Smith, et al., 2005; Turban, et al., 2022). These studies consistently demonstrate improvement of gender dysphoria with associated improvement of psychological functioning. A 2014 long-term follow-up study following patients from early adolescence through young adulthood showed that gender-affirming treatment allowed transgender adolescents to make age-appropriate developmental transitions while living as their affirmed gender with positive outcomes as young adults (de Vries, et al., 2014). More recently, Green et al. (2022) describe that gender-affirming hormone therapy is correlated with reduced rates of depression and suicidality among transgender adolescents. Turban et al. (2022) documented that access to gender-affirming hormone therapy in adolescence is associated with favorable mental health outcomes in adulthood, when compared to individuals who desired but could not access hormonal interventions.

35. It should be noted here, as will be elaborated upon in later sections of this declaration, that *all* evidence demonstrating safety and efficacy of gender affirming care for transgender adolescents was conducted in settings where both pubertal suppression *and* gender-affirming hormonal interventions were legal and available as a *series* of interventions. There are no jurisdictions worldwide that I am aware of that allow for treatment of gender dysphoria in adolescents with gonadotropin-releasing hormone (“GnRHa”) agonists (often referred to as puberty blockers) while simultaneously banning gender affirming hormones, as is proposed in Georgia.

36. If Senate Bill 140 is passed, it will create a medical scenario never envisioned when evidence-based protocols pertaining to this care were being created. Providers attempting to continue to provide care will be faced with impossible medical, logistical, and ethical challenges in this ill-conceived and illogical attempt at “less harsh” or “less extreme” ban on gender affirming care.

C. ASSESSMENT OF GENDER DYSPHORIA IN CHILDREN AND ADOLESCENTS

37. Due to the incongruence between their assigned sex and gender identity, transgender people experience varying degrees of gender dysphoria, a serious medical condition defined in the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5 TR) (APA, 2022). *Gender Dysphoria* is defined as an incongruence between a patient’s assigned sex and their gender identity present

for at least six months, which causes clinically important distress in the person's life. This distress is further defined as impairment in social, occupational, or other important areas of functioning (APA, 2022). Additional features may include a strong desire to be rid of one's primary or secondary sex characteristics, a strong desire to be treated as a member of the identified gender, or a strong conviction that one has the typical feelings of identified gender (APA, 2022).

38. The World Health Organization's International Classification of Diseases (ICD), the diagnostic and coding compendia for mental health and medical professionals, codifies Gender Incongruence as the diagnosis resulting from the incongruity between one's gender identity and birth sex. The Gender Incongruence diagnosis is part of a "Conditions related to sexual health" chapter in the ICD-11, which is the most recent iteration of the ICD published in 2019 (Costa, et al., 2015; WHO, 2019). This reflects evidence that transgender and gender diverse identities are not conditions of mental ill health and classifying them as such can cause enormous stigma.

39. Although diagnoses of gender dysphoria remain relatively rare, they have increased over time as greater awareness and scientific attention have yielded more information and resources for clinicians. There is not, as I understand the Georgia legislature cited as a basis for the Ban, an "unexplained rise in diagnoses" of gender dysphoria." S.B. 140. § (1)(1). There is an obvious explanation for any perceived "rise in diagnoses": a reduction in stigma and mistreatment of the condition.

40. In children and adolescents, the diagnosis of gender dysphoria is made by a health provider including but not limited to a psychiatrist, psychologist, social worker, or therapist with expertise in gender identity concerns. It is recommended that children and adolescents diagnosed with gender dysphoria engage with a multidisciplinary team of mental health and medical professionals to formulate a treatment plan, in coordination with the parent(s) or guardian(s), with a goal of reduction of gender dysphoria. The *Standards of Care for the Health of Transgender and Gender Diverse People, Version 8* (“SOC 8”), published by the World Professional Association for Transgender Health (WPATH), provides guidance to providers on how to provide comprehensive assessment and care to this patient population based on medical evidence. These standards recommend involving relevant disciplines, including mental health and medical professionals, to reach a decision with families about whether medical interventions are appropriate and remain indicated through the course of treatment. Multidisciplinary clinics, such as the Child and Adolescent Gender Clinic where I practice, have structured their programs around this model, as guided by the WPATH SOC.

D. EVIDENCE-BASED CLINICAL PRACTICE GUIDELINES FOR THE TREATMENT OF GENDER DYSPHORIA IN CHILDREN, ADOLESCENTS

41. The goal of any intervention for gender dysphoria is to reduce dysphoria, improve functioning, and prevent the harms caused by untreated gender dysphoria.

42. Gender dysphoria is highly treatable and can be effectively managed. If left untreated, however, it can result in severe anxiety and depression, eating disorders, substance abuse, self-harm, and suicidality (Reisner, et al., 2015).

43. Based on longitudinal data, and my own clinical experience, when transgender adolescents are provided with appropriate medical treatment and have parental and social support, they are more likely to thrive and grow into healthy adults (de Vries, et al., 2014).

44. In children and adolescents, a comprehensive biopsychosocial assessment is typically the first step in evaluation, performed by a mental health provider with experience in gender identity. The goals of this assessment are to develop a deep understanding of the young person's experience with gender identity, to consider whether the child or adolescent meets criteria for a diagnosis of gender dysphoria, and to understand what options may be desired and helpful for the adolescent (Coleman, et al., 2022; Coleman, et al., 2012; Hembree, et al., 2017; Hembree, et al., 2009).

45. For children younger than pubertal age, recommended treatments do not involve medications. For adolescents, additional treatments involving medications may be appropriate.

46. For pre-pubertal children with gender dysphoria, treatments may include supportive therapy, encouraging support from loved ones, and assisting the young

person through elements of a social transition. Social transition may include adopting a new name and pronouns, appearance, and clothing, and correcting identity documents.

47. Options for treatment after the onset of puberty include the use of GnRHa for purposes of preventing progression of pubertal development, and hormonal interventions such as testosterone and estrogen administration. These treatment options are based on robust research and clinical experience, which consistently demonstrate safety and efficacy. For patients presenting in early puberty, GnRHa and hormonal interventions are typically used in sequence, with GnRHa used in early adolescence, followed by hormonal interventions in later adolescence provided there is persistence of a gender identity different from the patient's natal sex. For patients presenting after puberty, hormonal interventions are considered without use of GnRHa.

48. Clinical practice guidelines have been published by several long-standing and well-respected medical bodies: the World Professional Association for Transgender Health (WPATH) and the Endocrine Society (Coleman, et al., 2022; Coleman, et al., 2012; Hembree, et al., 2017; Hembree, et al., 2009), as well as the UCSF Center for Excellence in Transgender Health (Deutsch (ed.), 2016). The clinical practice guidelines and standards of care published by these organizations provide a framework for treatment of gender dysphoria in adolescents.

49. WPATH has been recognized as the standard-setting organization for the

treatment of gender dysphoria since its founding in 1979. The most recent WPATH Standards of Care (SOC 8) were published in 2022 and represent expert consensus for clinicians related to medical care for transgender people, based on the best available science and clinical experience (Coleman, et al., 2022).

50. The purpose of the WPATH Standards of Care is to assist health providers in delivering necessary medical care to transgender people, to maximize their patients' overall health, psychological well-being, and self-fulfillment. The WPATH Standards of Care serve as one of the foundations for the care provided in my own clinic.

51. The WPATH SOC 8 is based on rigorous review of the best available science and expert professional consensus in transgender health. International professionals were selected to serve on the SOC 8 writing committee. Recommendation statements were developed based on data derived from independent systemic literature reviews. Grading of evidence was performed by an Evidence Review Team which determined the strength of evidence presented in each individual study relied upon in the document (Coleman, et al., 2022).

52. The previous version (SOC 7), published in 2012 (Coleman, et al., 2012), was similar to SOC 8 in the basic tenets of management for transgender adolescents; however, SOC 8 further reinforces these guidelines with data published since the release of SOC 7.

53. In addition, the Endocrine Society is a 100-year-old global membership organization representing professionals in the field of adult and pediatric endocrinology. In 2017, the Endocrine Society published clinical practice guidelines on treatment recommendations for the medical management of gender dysphoria, in collaboration with Pediatric Endocrine Society, the European Societies for Endocrinology and Pediatric Endocrinology, and WPATH, among others (Hembree, et al, 2017).

54. The Endocrine Society Clinical Guidelines were developed through rigorous scientific processes that “followed the approach recommended by the Grading of Recommendations, Assessment, Development, and Evaluation group, an international group with expertise in the development and implementation of evidence-based guidelines.” The guidelines affirm that patients with gender dysphoria often must be treated with “a safe and effective hormone regimen that will (1) suppress endogenous sex hormone secretion determined by the person’s genetic/gonadal sex and (2) maintain sex hormone levels within the normal range for the person’s affirmed gender.” (Hembree, et al., 2017).

55. The AAP is the preeminent professional body of pediatricians in the United States, with over 67,000 members. The AAP endorses a commitment to the optimal physical, mental, and social health and well-being for youth. The 2018 policy statement titled *Ensuring Comprehensive Care and Support for Transgender and*

Gender-Diverse Children and Adolescents further lends support to the treatment options outlined in the WPATH Standards of Care and the Endocrine Society's Clinical Practice Guidelines (Rafferty, et al., 2018).

56. Aside from the AAP, the tenets set forth by the Endocrine Society Clinical Practice Guidelines and the WPATH Standards of Care are supported by the major professional medical and mental health associations in the United States, including the American Medical Association, the American Psychological Association, the American Psychiatric Association, and American Academy of Family Physicians, among others (e.g., AMA, 2019; American Psychological Association, 2015; Drescher, et al., 2018 (American Psychiatric Association); Hembree, et al., 2017 (Endocrine Society); Klein, et al., 2018 (AAFP); National Academies, 2020; WPATH, 2016).

57. As a board-certified pediatric endocrinologist, I follow the Endocrine Society Clinical Practice Guidelines and the WPATH Standards of Care when treating my patients.

E. TREATMENT PROTOCOLS FOR GENDER DYSPHORIA IN CHILDREN AND ADOLESCENTS

58. Central to the guidance from WPATH, the Endocrine Society, and the AAP is the importance of familial love and support. Transgender youth who report high levels of rejection from family have lower self-esteem and higher degrees of isolation. These youth are at very high risk for health and mental health problems when

they become young adults. According to the Family Acceptance Project, transgender young people who reported high levels of family rejection are significantly more likely to have attempted suicide, to report high levels of depression, to use illegal drugs, and to be at high risk for HIV and sexually transmitted diseases compared with transgender young people who report no or low levels of rejection by family due to their identity (Ryan, et al., 2010).

59. Undergoing treatment to alleviate gender dysphoria is commonly referred to as a transition. The transition process in adolescence typically includes (i) social transition and/or (ii) medications, including puberty-delaying medication and hormone therapy. The steps that make up a person's transition and their sequence will depend on that individual's medical and mental health needs and decisions made between the patient, family, and multidisciplinary care team.

60. There are no medications considered for transition until after the onset of puberty. Puberty is a process of maturation heralded by production of sex hormones—testosterone and estrogen—leading to the development of secondary sex characteristics. Secondary sex characteristics include testosterone-induced effects such as deepening of the voice, muscular changes, facial and body hair, and estrogen-induced effects such as breast development. There is diversity in the age of pubertal onset; however, most adolescents begin puberty between ages 10 and 12 years.

61. Gender exploration in childhood is expected and healthy. The majority

of prepubertal children exploring their gender do not develop gender dysphoria and are not expected to become transgender adolescents or adults. In contrast, data and personal experience shows that children whose gender dysphoria persists into adolescence are highly likely to be transgender (van der Loos, et al., 2022). Some individuals in this field misinterpret older studies showing that a large percentage of children diagnosed with gender identity disorder did not grow up to be transgender. Those studies include children who would not fulfill the current diagnostic criteria for gender dysphoria and, in any case, have no relevance to this case because prepubertal children are not prescribed hormone therapy.

62. Puberty-delaying medication and hormone-replacement therapy—both individually and in combination—can significantly improve a transgender young person’s mental health. These treatments allow for a physical appearance more closely aligning with gender identity and decreases the likelihood that a transgender young person will be incorrectly identified with their assigned sex, further alleviating their gender dysphoria, and bolstering the effectiveness of their social transition.

63. At the onset of puberty, adolescents begin to experience the onset of secondary sex characteristics. Adolescents with differences in gender identity may have intensification of gender dysphoria during this time due to development of secondary sex characteristics incongruent with gender identity. Persistence or intensification of gender dysphoria as puberty begins is used as a helpful diagnostic

tool as it becomes more predictive of gender identity persistence into adolescence and adulthood (de Vries, et al., 2012).

64. The rationale for intervening during adolescence is straightforward: puberty and the development of permanent secondary sex characteristics happen during adolescence. To prevent distress associated with development of unwanted sex characteristics, and to develop secondary sex characteristics consistent with gender identity in an age-appropriate manner, treatment during adolescence is required. Proponents of a so-called “wait and see” approach—advocating for no treatment until the age of legal consent—are ignoring the significant physical and mental health benefit of early intervention in appropriately assessed and counseled patients and families.

i. Treatment with puberty-delaying medications

65. Adolescents diagnosed with gender dysphoria who have entered puberty (Tanner Stage 2) may be prescribed puberty-delaying medications (GnRHa) to prevent the distress of developing permanent, unwanted physical characteristics that do not align with the adolescent’s gender identity. Tanner Stage 2 refers to the stage in puberty whereby the physical effects of testosterone or estrogen production are first apparent on physical exam. Specifically, this is heralded by the onset of breast budding in an individual assigned female at birth, or the onset of testicular enlargement in an individual assigned male at birth. For individuals assigned male at birth, Tanner Stage

2 typically occurs between age 9–14, and for those assigned female at birth between age 8–12.

66. The treatment works by pausing endogenous puberty at whatever stage it is at when the treatment begins, limiting the influence of a person’s endogenous hormones on their body. For example, a transgender girl will experience no progression of physical changes caused by testosterone, including facial and body hair, an Adam’s apple, or masculinized facial structures. And, in a transgender boy, those medications would prevent progression of breast development, menstruation, and widening of the hips (Coleman, et al., 2022; de Vries, et al., 2012; Deutsch (ed.), 2016; Hembree, et al., 2017; Rosenthal, 2014).

67. GnRHa have been used extensively in pediatrics for several decades. Prior to their use for gender dysphoria, they were used (and still are used) to treat precocious puberty. GnRHa work by suppressing the signal hormones from the pituitary gland (luteinizing hormone [LH] and follicle stimulating hormone [FSH]) that stimulate the testes or ovaries to produce sex hormones. Upon discontinuation of GnRHa, LH and FSH production resume and puberty will also resume.

68. GnRHa have no long-term implications on fertility. In transgender youth, it is most typical to use GnRHa from the onset of puberty (Tanner Stage 2) until mid-adolescence. While treating, the decision to continue treatment will be continually evaluated. Should pubertal suppression no longer be desired, GnRHa would be

discontinued, and puberty would re-commence.

69. Prior to initiation of GnRHa, providers counsel patients and their families extensively on potential benefits and risks. The designed benefit of the treatment is to reduce the risk of worsening gender dysphoria and mental health deterioration. Furthermore, development of secondary sex characteristics incongruent with gender identity could result in the future need for surgeries and other body alterations that would not be needed if GnRHa had been used.

70. As an experienced pediatric endocrinologist, I treat patients with these same medications for both precocious puberty and gender dysphoria and in both cases the side effects are comparable and easily managed. And for both patient populations the risks are greatly outweighed by the benefits of treatment.

71. In addition, there are patients who do not meet criteria for precocious puberty but who may require pubertal suppression. I prescribe GnRHa to adolescents with growth hormone deficiency, who despite growth hormone treatment, will have a very short adult height. Patients with disabilities who are unable to tolerate puberty at the typical age due to hygienic concerns and young women with endometriosis may also be prescribed GnRHa. In these situations, the use of GnRHa should be thought of as temporary and temporizing treatment to bridge to a longer-term solution. Patients are typically prescribed GnRHa for no longer than three years as prolonged length of treatment is neither recommended due to the importance of eventual exposure to

pubertal hormones on bone health nor necessary because during the course of treatment, a long-term plan to address the underlying problem would have been made.

72. As with gender dysphoria, the prescription of GnRHa to treat the conditions described in paragraph 69 above is “off-label,” yet it is widely accepted within the field of endocrinology and not considered experimental. The same holds true for other common medications used in pediatric endocrinology: using metformin for weight loss; growth hormone for short stature not caused by growth hormone deficiency; countless medications used to control type 2 diabetes which have an adult indication but whose manufacturers have not applied for a pediatric indication.

ii. Treatment with hormone therapy

73. In mid-adolescence, the patient, their parents, and the patient’s care team may discuss the possibility of beginning the use of testosterone or estrogen. Providers discuss these treatments for patients currently receiving GnRHa, or for patients who have already gone through their endogenous puberty and either did not have access to, desire, or elect for GnRHa treatment.

74. These hormone therapies are used to treat gender dysphoria in adolescents to facilitate development of sex-specific physical changes congruent with their gender identity. For example, a transgender boy prescribed testosterone will develop a lower voice as well as facial and body hair, while a transgender girl prescribed estrogen will experience breast growth, female fat distribution, and softer

skin.

75. Under the Endocrine Society Clinical Guidelines and SOC 8, hormone therapy is an appropriate treatment for transgender adolescents with gender dysphoria when the experience of dysphoria is marked and sustained over time, the adolescent demonstrates emotional and cognitive maturity required to provide informed consent/assent for treatment, other mental health concerns (if any) that may interfere with diagnostic clarity and capacity to consent have been addressed, and the adolescent has discussed reproductive options with their provider. SOC 8 also highlights the importance of involving parent(s)/guardian(s) in the assessment and treatment process for minors (Coleman, et al., 2022; Hembree, et al., 2017).

76. Similar to GnRHa, the risks and benefits of hormone treatment are discussed with patients (and families, if the patient is a minor) prior to initiation of testosterone or estrogen. When treated with testosterone or estrogen, the goal is to maintain the patient's hormone levels within the normal range for their gender. Laboratory testing is recommended to ensure proper dosing and hormonal levels. If starting hormonal care after completing puberty, discussion of egg or sperm preservation prior to starting treatment is recommended.

77. Regardless of the treatment plan prescribed, at every encounter with the care team there is a re-evaluation of the patient's gender identity and their transition goals. Should a patient desire to discontinue a medical intervention, the intervention is

discontinued. Discontinuation of GnRHa will result in commencement of puberty. Discontinuation of testosterone or estrogen would arrest progression of masculinization or feminization, respectively. The patient would begin to produce endogenous hormones at typical levels to others with the same sex assigned at birth after discontinuation. Some of the effects of testosterone and estrogen are expected to be relatively permanent (e.g. voice deepening with testosterone, breast development with estrogen) while others are non-permanent (e.g. fat and musculature changes, arrest of the menstrual cycle, skin changes). Findings from studies in which participants have undergone comprehensive evaluation prior to gender care show very low levels of regret (de Vries, et al., 2011; van der Loos, et al., 2022; Wiepjes, et al., 2018).

78. Surgical interventions, including but not limited to chest and genital surgery, are indicated in appropriately selected patients. These surgeries are not typically performed in adolescence but rather considered in adulthood. Surgical care is not addressed in this case. The WPATH SOC 8 outlines the current literature supporting benefits of surgical interventions for patients with gender dysphoria (Coleman, et al., 2022).

F. SAFETY AND EFFICACY OF PUBERTY-DELAYING MEDICATIONS AND HORMONE THERAPY TO TREAT GENDER DYSPHORIA

79. GnRHa, prescribed for delaying puberty in transgender adolescents, is

both a safe and effective treatment. While GnRHa are not banned under Senate Bill 140, a thorough understanding of this intervention is required to understand gender affirming care for adolescents more broadly. This is because whenever discussing the use of GnRHa, it should be thought of as a temporary treatment or a bridge; a way to delay decision making regarding hormonal treatments until later adolescence.

80. Patients under consideration for treatment with GnRHa are working within a multidisciplinary team of providers all dedicated to making informed and appropriate decisions with the patient and family in the best interest of the adolescent. Physicians providing this intervention are trained and qualified in gender identity concerns and childhood growth and development and are participating in this care out of a desire to improve the health and wellness of transgender youth and prevent negative outcomes such as depression and suicide.

81. GnRHa, including injectable leuprolide and implantable histrelin, have rare side effects which are discussed with patients and families prior to initiation. Mild negative effects may include pain at the injection or implantation site, sterile abscess formation, weight gain, hot flashes, abdominal pain, and headaches. These effects can be seen in patients receiving GnRHa for gender dysphoria, or for other indications such as precocious puberty. I counsel patients on maintaining a healthy diet and promote physical activity, and regularly document height and weight during treatment. Nutritional support can be provided for patients at risk for obesity.

82. Risk of lower bone mineral density in prolonged use of GnRHa can be mitigated by screening for, and treating, vitamin D deficiency when present, and by limiting the number of years of treatment based on a patient's clinical course (Rosenthal, 2014). An exceptionally rare but significant side effect, increased intracranial pressure, has been reported in six patients (five treated for precocious puberty, one for transgender care), prompting an FDA warning in July 2022 (AAP, 2022). These cases represent an extremely small fraction of the thousands of patients who have been treated with GnRHa over decades. Symptoms of this side effect (headache, vomiting, visual changes) are reviewed with families and if they occur the medication is discontinued.

83. GnRHa do not have long-term implications on fertility. This is clearly proven from decades of use in the treatment of precocious puberty (Guaraldi, et al., 2016; Martinerie, et al, 2021). Progression through natal puberty is required for maturation of egg or sperm. If attempting fertility after previous treatment with GnRHa followed by hormone therapy is desired, an adult patient would withdraw from hormones and allow pubertal progression. Assistive reproduction could be employed if needed (T'Sjoen, et al., 2013).

84. Patients who initiate hormones after completing puberty are offered gamete preservation prior to hormonal initiation (Coleman, et al., 2022), but even when not undertaken, withdrawal of hormones in adulthood often is successful in

achieving fertility when it is desired (Light, et al., 2014; Knudson, et al., 2017).

85. Discussing the topic of fertility is important, and not specifically unique to treatment of gender dysphoria. Medications used for other medical conditions, such as chemotherapeutics used in cancer treatment, can affect fertility. For all medications with potential impacts on fertility, the potential risks and benefits of both treatment and non-treatment should be reviewed and data regarding risk for infertility clearly articulated prior to the consent or assent of the patient. Risk for fertility changes must be balanced with the risk of withholding treatment.

86. Review of relevant medical literature clearly supports the benefits of GnRHa treatment on both short-term and long-term psychological functioning and quality of life (e.g., Achille, et al., 2020; Carmichael, et al., 2021; Costa, et al., 2015; de Vries, et al., 2014; de Vries, et al., 2011; Kuper, et al., 2020; Turban, et al., 2020b; van der Miesen, et al., 2020). For example, a 2014 long-term follow-up study following patients from early adolescence through young adulthood showed that gender-affirming treatment allowed transgender adolescents to make age-appropriate developmental transitions while living as their affirmed gender with positive outcomes as young adults (de Vries, et al., 2014).

87. In my own practice, adolescent patients struggling with significant distress at the onset of puberty routinely have dramatic improvements in mood, school performance, and quality of life with appropriate use of GnRHa. Side effects

encountered are similar to those seen in other patients treated with these medications and easily managed.

88. That said, GnRHa should not be given indefinitely for several reasons. First, delaying a person's puberty until age 18 would be socially devastating for any person. Secondly, puberty is important for many reasons beyond the development of secondary sex characteristics. For example, and as will be discussed below, bone density increases during puberty. Therefore, GnRHa are used only as long as medically necessary. The provider, patient and family are attempting to balance the goal of delaying medical decision-making regarding hormones with the advantages of a relatively normally timed puberty.

89. Hormone therapy (testosterone or estrogen) is prescribed to older adolescents with gender dysphoria. As is the case with GnRHa, the need for hormone therapy is not unique to transgender adolescents. Patients with conditions such as delayed puberty, hypogonadism, Turner Syndrome, Klinefelter Syndrome, agonadism, premature ovarian failure, and disorders of sex development all require treatment with these hormones, often starting in adolescence and continuing lifelong. Without testosterone or estrogen treatment, these patients would be unable to progress through puberty normally, which would have serious medical and social consequences. Whether used in adolescents to treat gender dysphoria, or to treat any of these other conditions, testosterone and estrogen are prescribed with a goal to raise the testosterone

or estrogen level into the normal male or female range for the patient's age. Careful monitoring of blood levels and clinical progress are required. Side effects are rare, but most often related to overtreatment, which can be minimized with this monitoring. Additionally, side effects are considered, discussed, and easily managed in all individuals needing hormone therapy regardless of the diagnosis necessitating these medications.

90. Venous thromboembolism (blood clotting) is a known side effect of estrogen therapy in all individuals placed on it including transgender women. Risk is increased in old age, in patients with cancer, and in patients who smoke nicotine. This side effect is mitigated by careful and accurate prescribing and monitoring. In my career, no patient has suffered a thromboembolism while on estrogen therapy.

91. Treatment of gender dysphoria with testosterone or estrogen is highly beneficial for both short-term and long-term psychological functioning of adolescents with gender dysphoria and withholding treatment from those who need it is harmful (e.g., Achille, et al., 2020; Allen, et al., 2019; Chen, et al., 2023; de Lara, et al., 2020; de Vries, et al., 2014; Grannis, et al., 2021; Green, et al., 2022; Kaltiala, et al., 2020; Kuper, et al., 2020). To highlight examples, Green et al. (2022) describe that gender-affirming hormone therapy is correlated with reduced rates of depression and suicidality among transgender adolescents. Turban et al. (2022) documented that access to gender-affirming hormone therapy in adolescence is associated with

favorable mental health outcomes in adulthood, when compared to individuals who desired but could not access hormonal interventions.

92. I treat many patients with gender dysphoria with GnRHa, testosterone, and estrogen. Side effects related to these medications are very rare and can be treated with dose adjustment and/or lifestyle changes.

93. In sum, the use of GnRHa and hormones in adolescents for the treatment of gender dysphoria is the current standard of care and certainly not experimental. This is due to robust evidence of safety and efficacy. The sum of the data supports the conclusion that treatment of gender dysphoria with these interventions promotes wellness and helps to prevent negative mental health outcomes, including suicidality in adolescents. The data to support these interventions are so strong that withholding such interventions would be negligent and unethical.

G. ALLOWING THE USE OF GnRHa WHILE SIMULTANEOUSLY BANNING HORMONAL CARE DEMONSTRATES AN ALARMING LACK OF MEDICAL UNDERSTANDING

94. Senate Bill 140 is unique when compared to similar bills being attempted in other States in that it explicitly bans gender affirming hormone care for adolescents with gender dysphoria while allowing for the use of GnRHa. Regardless of the motivation behind banning hormone therapy but not the use of GnRHa, it only serves to highlight a deep lack of understanding of medicine, gender dysphoria, and the evidence-based treatment options available.

95. When Dutch physicians first described the use of GnRHa in transgender adolescents, they were describing a medical dilemma. Transgender adolescents in early stages of puberty experience unwanted permanent changes to their bodies which cause intense distress. They are, however, at an age younger than ideal to make decisions which have permanent implications. These authors pointed out that when a youth has persistence of transgender identity at the onset of puberty, persistence into adulthood becomes highly likely. Even still, the use of GnRHa was proposed to delay the decision regarding hormones until later adolescence, when a deeper and more meaningful conversation regarding risks and benefits of treatment is possible (de Vries, Cohen-Kettenis, 2012). It was never proposed, and would not be logical to assume, that treatment with GnRHa alone would constitute a safe or meaningful long-term plan. Exposure to sex hormones, either testosterone or estrogen, is critical for every person. A patient appropriately treated with GnRHa in early puberty, who is now in later adolescence and eligible for a hormonal intervention would be left with three options: (1) discontinue GnRHa and allow for puberty to resume (not safe from a mental health perspective); (2) continue GnRHa until age 18 (not safe from a medical perspective); or (3) move out of State to continue care elsewhere.

96. GnRHa allows for delayed decision making, but at some point, everyone must be exposed to pubertal hormones. Transgender youth do want to and need to undergo growth and development.

97. An analogy to better understand the roles of GnRHa and hormone therapy is by considering GnRHa as a bridge to the next decision point: either discontinuation in the case of desistance of gender dysphoria (which is rare) or progression to hormonal care (extremely common). Allowing GnRHa while simultaneously banning hormonal care would be like constructing a “bridge to nowhere.” At the end of the bridge, you have nowhere to go and simply fall.

98. An analogy related to Pediatric Endocrinology involves the thyroid condition Graves Disease. In Graves Disease, the thyroid is overstimulated by the body’s immune system to produce excessive amounts of thyroid hormone. The result is hyperthyroidism (thyroid hormone levels are too high). The first line of treatment for this condition is a medication called methimazole. Methimazole impairs the ability of the thyroid to produce thyroid hormone. When used to treat Graves Disease, methimazole lowers the thyroid hormone level back to normal. However, methimazole does nothing to solve the underlying problem, the immune system is continuing to overstimulate the thyroid gland. Pediatric Endocrinologists continue methimazole for 1 to 3 years, hoping that the Graves Disease will go into remission. If it does, methimazole can be stopped. If it does not, it is less than ideal to continue methimazole as a life-long medication. Therefore, in cases of persisting Graves Disease, thyroidectomy (removal of the thyroid) is recommended. In this analogy, if thyroidectomy were banned, providers would have a tool to treat Graves Disease when

it is diagnosed but would not have an option for safe and effective long-term management.

H. HARMS ASSOCIATED WITH PROHIBITING AND DISCONTINUING TREATMENT

99. Prohibition of the full complement of gender-affirming care for adolescents is likely to have devastating consequences. I am concerned such a prohibition might lead to a staggering increase in mental health problems including suicidality for transgender children and adolescents in Georgia. One study which highlights my concern is a study of over 21,000 patients who report ever desiring gender-affirming hormone care. When comparing those who were able to access this care to those desiring but never accessing care, those able to access care had lower odds of suicidality within the past year. In addition, those individuals who were able to access care in adolescence had lower odds of suicidality compared to those waiting to access until adulthood (Turban, et al., 2022).

100. Even more concerning is a situation where patients currently receiving care and thriving would be forced to discontinue this care. As outlined in Section G, patients treated with GnRHa without access to hormonal interventions would be placed in an extremely unique situation without precedent anywhere in the world and left with no safe options outside of obtaining care out of State. Adolescents in families without the means to travel for care would face potentially catastrophic consequences.

III. CONCLUSION

101. In summary, banning hormone therapy for adolescent children runs counter to evidence-based best practices and standards of care for the treatment of gender dysphoria.

102. Gender dysphoria is a challenging condition, but it is treatable through individualized assessment and treatment, which may include social transition, psychotherapy, pubertal suppression, and hormonal therapy. These treatments are not experimental and are supported by all major medical bodies in the field of transgender medicine and pediatrics.

103. Lack of access to these treatments will result in worse outcomes for countless youth in Georgia. Furthermore, banning coverage for evidence-based treatment for gender dysphoria sends a message that transgender youth are not valid and should be stigmatized.

104. In my own clinical practice in Michigan, I have seen an influx of patients from states banning medically proven treatments for gender dysphoria who report not feeling safe living in the community that they have always called home. Parents who love and support their transgender children have described themselves as “refugees” in their own country, moving to avoid discriminatory laws which they know would clearly harm their health or the health of their child.

105. Banning coverage of effective treatment for gender dysphoria will not eliminate transgender youth, but will, unfortunately, lead to an increase in mental

health problems and suicidality in an already vulnerable population.

I declare under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

Executed this 28th day of June 2023.



Daniel Shumer, M.D.

Exhibit A
Curriculum Vitae

Daniel Shumer, MD MPH

Clinical Associate Professor in Pediatrics - Endocrinology

Email: dshumer@umich.edu

EDUCATION AND TRAINING

Education

- 08/2000-08/2003 BA, Northwestern University, Evanston, United States
08/2004-05/2008 MD, Northwestern University, Feinberg School of Medicine, Chicago, United States
07/2013-05/2015 MPH, Harvard T.H. Chan School of Public Health, Boston, United States

Postdoctoral Training

- 06/2008-06/2011 Residency, Pediatrics, Vermont Children's Hospital at Fletcher Allen Health Care, Burlington, VT
07/2011-06/2012 Chief Resident, Chief Resident, Vermont Children's Hospital at Fletcher Allen Health Care, Burlington, VT
07/2012-06/2015 Clinical Fellow, Pediatric Endocrinology, Boston Children's Hospital, Boston, MA

CERTIFICATION AND LICENSURE

Certification

- 10/2011-Present American Board of Pediatrics, General

Licensure

- 08/2015-Present Michigan, Medical License
09/2015-Present Michigan, DEA Registration
09/2015-Present Michigan, Controlled Substance

WORK EXPERIENCE

Academic Appointment

- 10/2015-9/2022 Clinical Assistant Professor in Pediatrics - Endocrinology,
University of Michigan - Ann Arbor, Ann Arbor
- 09/2022-Present Clinical Associate Professor in Pediatrics - Endocrinology,
University of Michigan - Ann Arbor, Ann Arbor

Administrative Appointment

- 07/2019-Present Fellowship Director - Pediatric Endocrinology, Michigan
Medicine, Department of Pediatrics, Ann Arbor
- 07/2020-Present Medical Director of the University of Michigan
Comprehensive Gender Services Program, Michigan
Medicine, Ann Arbor
- Oversee the provision of care to transgender and gender non-conforming patients at Michigan Medicine.*
- 07/2020-Present Education Lead - Pediatric Endocrinology, University of
Michigan - Department of Pediatrics, Ann Arbor

Clinical Appointments

- 04/2022-05/2023 Medical Director in UMMG Faculty Benefits Appt.,
University of Michigan - Ann Arbor, Ann Arbor

Private Practice

- 08/2013-09/2015 Staff Physician, Harvard Vanguard Medical Associates,
Braintree

RESEARCH INTERESTS

- Gender dysphoria
- Prader Willi Syndrome

CLINICAL INTERESTS

- Gender dysphoria
- Disorders of Sex Development
- Prader Willi Syndrome

GRANTS

Past Grants

A Phase 2b/3 study to evaluate the safety, tolerability, and effects of Livoletide (AZP-531), an unacylated ghrelin analog, on food-related behaviors in patients with Prader-Willi syndrome

PI

Millendo Therapeutics

04/2019 - 04/2021

HONORS AND AWARDS

National

2014 Annual Pediatric Endocrine Society Essay Competition:
Ethical Dilemmas in Pediatric Endocrinology: competition
winner - The Role of Assent in the Treatment of Transgender
Adolescents

Institutional

2012 - 2015 Harvard Pediatric Health Services Research Fellowship;
funded my final two years of pediatric endocrine fellowship
and provided tuition support for my public health degree

- 2016 The University of Michigan Distinguished Diversity Leaders Award, awarded by The Office of Diversity, Equity and Inclusion to the Child and Adolescent Gender Services Team under my leadership
- 2019 Lecturer of the Month, Department of Pediatrics, Michigan Medicine

TEACHING MENTORSHIP

Resident

- 07/2020-Present Rebecca Warwick, Michigan Medicine (co-author on publication #22)

Clinical Fellow

- 07/2017-06/2020 Adrian Araya, Michigan Medicine (co-author on publication #22, book chapter #4)
- 12/2020-Present Jessica Jary, Michigan Medicine - Division of Adolescent Medicine

Medical Student

- 09/2017-06/2020 Michael Ho, Michigan Medicine
- 07/2019-Present Hadrian Kinnear, University of Michigan Medical School (co-author on book chapter #3, abstract #3)
- 07/2019-Present Jourdin Batchelor, University of Michigan

TEACHING ACTIVITY

Regional

- 08/2018-Present Pediatric Boards Review Course sponsored by U-M: "Thyroid Disorders and Diabetes". Ann Arbor, MI

Institutional

- 12/2015-12/2015 Pediatric Grand Rounds: "Transgender Medicine - A Field in Transition". Michigan Medicine, Ann Arbor, MI
- 02/2016-02/2016 Medical Student Education: Panelist for M1 Class Session on LGBT Health, Doctoring Curriculum. Michigan Medicine, Ann Arbor, MI
- 02/2016-02/2016 Psychiatry Grand Rounds: "Transgender Medicine - A Field in Transition". Michigan Medicine, Ann Arbor, MI
- 03/2016-03/2017 Pharmacy School Education: "LGBT Health". University of Michigan School of Pharmacy, Ann Arbor, MI
- 04/2016-Present Course Director: Medical Student (M4) Elective in Transgender Medicine. Michigan Medicine, Ann Arbor, MI
- 04/2016-04/2016 Rheumatology Grand Rounds: "Gender Identity". Michigan Medicine, Ann Arbor, MI
- 05/2016-05/2016 Lecture to Pediatric Rheumatology Division: "Gender Dysphoria". Michigan Medicine, Ann Arbor, MI
- 07/2016-07/2016 Internal Medicine Resident Education: "Gender Identity". Michigan Medicine, Ann Arbor, MI
- 09/2016-09/2016 Presentation to ACU Leadership: "Gender Identity Cultural Competencies". Michigan Medicine, Ann Arbor, MI
- 10/2016-10/2016 Presentation to Department of Dermatology: "The iPledge Program and Transgender Patients". Michigan Medicine, Ann Arbor, MI
- 02/2017-02/2017 Swartz Rounds Presenter. Michigan Medicine, Ann Arbor, MI
- 02/2017-02/2017 Lecture to Division of General Medicine: "Transgender Health". Michigan Medicine, Ann Arbor, MI

- 02/2017-02/2017 Presentation at Collaborative Office Rounds: "Transgender Health". Michigan Medicine, Ann Arbor, MI
- 10/2017-10/2017 Family Medicine Annual Conference: "Transgender Medicine". Michigan Medicine, Ann Arbor, MI
- 12/2017-12/2017 Presenter at Nursing Unit 12-West Annual Educational Retreat: "Gender Identity at the Children's Hospital". Michigan Medicine, Ann Arbor, MI
- 02/2018-Present Pediatrics Residency Lecturer: "Puberty". Michigan Medicine, Ann Arbor, MI
- 02/2019-Present Medical Student (M1) Lecturer: "Pediatric Growth and Development". Michigan Medicine, Ann Arbor, MI
- 02/2019-Present Doctors of Tomorrow Preceptor: offering shadowing opportunities to students from Cass Technical High School in Detroit. Michigan Medicine, Ann Arbor, MI
- 03/2019-03/2019 Lecture to Division of Orthopedic Surgery: "Transgender Health". Michigan Medicine, Ann Arbor, MI

MEMBERSHIPS IN PROFESSIONAL SOCIETIES

- 2012 - Present Pediatric Endocrine Society

COMMITTEE SERVICE

National

- 2014 - 2016 Pediatric Endocrine Society - Ethics Committee, Other, Member
- 2017 - present Pediatric Endocrine Society - Special Interest Group on Gender Identity, Other, Member
- 2018 - present Pediatric Endocrine Society - Program Directors Education Committee, Other, Member

Regional

2013 - 2015 Investigational Review Board - The Fenway Institute, Boston, MA, Other, Voting Member

Institutional

2017 - 2019 Department of Pediatrics at Michigan Medicine; Diversity, Equity, and Inclusion Committee, Other, Fellowship Lead

2017 - 2019 University of Michigan Transgender Research Group, Other, Director

VOLUNTEER SERVICE

2014 Camp Physician, Massachusetts, Served at a camp for youth with Type 1 Diabetes

SCHOLARLY ACTIVITIES

PRESENTATIONS

Extramural Invited Presentation Speaker

1. Grand Rounds, Shumer D, Loyola University School of Medicine, 07/2022, Chicago, Illinois

Other

1. Gender Identity, Groton School, 04/2015, Groton, MA

2. Television Appearance: Gender Identity in Youth, Channel 7 WXYZ Detroit, 04/2016, Southfield, MI

3. It Gets Better: Promoting Safe and Supportive Healthcare Environments for Sexual Minority and Gender Non-Conforming Youth, Adolescent Health Initiative: Conference on Adolescent Health, 05/2016, Ypsilanti, MI

4. Gender Identity, Humanists of Southeast Michigan, 09/2016, Farmington Hills, MI

5. Gender Identity, Pine Rest Christian Mental Health Services, 10/2016, Grand Rapids, MI
6. Pediatric Grand Rounds - Hormonal Management of Transgender Youth, Beaumont Children's Hospital, 11/2016, Royal Oak, MI
7. Transgender Youth: A Field in Transition, Temple Beth Emeth, 11/2016, Ann Arbor, MI
8. Transgender Youth: A Field in Transition, Washtenaw County Medical Society, 11/2016, Ann Arbor, MI
9. Pediatric Grand Rounds: Transgender Youth - A Field in Transition, St. John Hospital, 02/2017, Detroit, MI
10. Transgender Medicine, Veterans Administration - Ann Arbor Healthcare System, 05/2017, Ann Arbor, MI
11. Gender Identity, Hegira Programs, 05/2017, Detroit, MI
12. Care of the Transgender Adolescent, Partners in Pediatric Care, 06/2017, Traverse City, MI
13. Conference planner, host, and presenter: Transgender and Gender Non-Conforming Youth: Best Practices for Mental Health Clinicians, Educators, & School Staff; 200+ attendees from fields of mental health and education from across Michigan, Michigan Medicine, 10/2017, Ypsilanti, MI
14. Endocrinology Grand Rounds: Transgender Medicine, Wayne State University, 11/2017, Detroit, MI
15. Care of the Transgender Adolescent, St. John Hospital Conference: Transgender Patients: Providing Compassionate, Affirmative and Evidence Based Care, 11/2017, Grosse Pointe Farms, MI
16. Hormonal Care in Transgender Adolescents, Michigan State University School of Osteopathic Medicine, 11/2017, East Lansing, MI
17. Working with Transgender and Gender Non-Conforming Youth, Michigan Association of Osteopathic Family Physicians, 01/2018, Bellaire, MI

18. Community Conversations, Lake Orion, 01/2018, Lake Orion, MI
19. "I Am Jazz" Reading and Discussion, St. James Episcopal Church, 03/2019, Dexter, MI
20. Gender Identity, Michigan Organization on Adolescent Sexual Health, 10/2019, Brighton, MI; Port Huron, MI
21. Ask The Expert, Stand With Trans, 05/2020, Farmington Hills, MI (Virtual due to COVID)
22. Transgender Medicine, Michigan Association of Clinical Endocrinologists Annual Symposium, 10/2020, Grand Rapids, MI (Virtual due to COVID)
23. Transgender Youth in Primary Care, Michigan Child Care Collaborative (MC3), 10/2020, Ann Arbor, MI (Virtual due to COVID)
24. Lets Talk About Hormones, Stand With Trans, 10/2020, Farmington Hills, MI (Virtual due to COVID)
25. Gender Identity, Universalist Unitarian Church of East Liberty, 04/2021, Virtual due to COVID
26. Unconscious Bias, Ascension St. John Hospital, 05/2021, Virtual due to COVID

PUBLICATIONS/SCHOLARSHIP

Peer-Reviewed Articles

1. Vengalil N, Shumer D, Wang F: Developing an LGBT curriculum and evaluating its impact on dermatology residents, *Int J Dermatol.* 61: 99-102, 01/2022. PM34416015

Chapters

1. Shumer: Coma. In Schwartz MW6, Lippincott Williams & Wilkins, Philadelphia, PA, (2012)
2. Shumer, Spack: Medical Treatment of the Adolescent Transgender Patient. In Đorđević M; Monstrey SJ; Salgado CJ Eds. CRC Press/Taylor & Francis, (2016)

3. Kinnear HA, **Shumer DE**: Duration of Pubertal Suppression and Initiation of Gender-Affirming Hormone Treatment in Youth. In FinlaysonElsevier, (2018)
4. Araya, **Shumer DE**: Endocrinology of Transgender Care – Children and Adolescents. In Poretsky; Hembree Ed. Springer, (2019)

Non-Peer Reviewed Articles

1. Shumer D: The Effect of Race and Gender Labels in the Induction of Traits, *Northwestern Journal of Race and Gender Criticism*.NA01/2014
2. Shumer D: A Tribute to Medical Stereotypes, *The Pharos, Journal of the Alpha Omega Alpha Medical Society*.Summer07/2017
3. Mohnach L, Mazzola S, Shumer D, Berman DR: Prenatal diagnosis of 17-hydroxylase/17,20-lyase deficiency (17OHD) in a case of 46,XY sex discordance and low maternal serum estriol, *Case Reports in Perinatal Medicine*.8(1)01/2018
4. Mohnach L, Mazzola S, Shumer D, Berman DR: Prenatal Diagnosis of 17-hydroxylase/17,20-lyase deficiency (17OHD) in a case of 46,XY sex discordance and low maternal serum estriol, *Case Reports in Perinatal Medicine*.8(1)12/2018
5. Kim C, Harrall KK, Glueck DH, **Shumer DE**, Dabelea D: Childhood adiposity and adolescent sex steroids in the EPOCH (Exploring Perinatal Outcomes among Children) study, *Clin Endocrinol (Oxf)*.91(4): 525-533, 01/2019. PM31278867
6. Araya A, Shumer D, Warwick R, Selkie E: 37. "I've Been Happily Dating For 5 Years" - Romantic and Sexual Health, Experience and Expectations in Transgender Youth, *Journal of Adolescent Health*.66(2): s20, 02/2020
7. Araya A, Shumer D, Warwick R, Selkie E: 73. "I think sex is different for everybody" - Sexual Experiences and Expectations in Transgender Youth, *Journal of Pediatric and Adolescent Gynecology*.33(2): 209-210, 04/2020
8. Araya AC, Warwick R, Shumer D, Selkie E, Rath T, Ibrahim M, Srinivasan A: Romantic Health in Transgender Adolescents, *Pediatrics*.Pediatrics01/2021
9. Martin S, Sandberg ES, **Shumer DE**: Criminalization of Gender-Affirming Care - Interfering with Essential Treatment for Transgender Children and

Adolescents, *New England Journal of Medicine*.385(7): 579-581, 08/2021.
PM34010528

Editorial Comment

1. **Shumer DE**, Harris LH, Opiari VP: The Effect of Lesbian, Gay, Bisexual, and Transgender-Related Legislation on Children, 01/2016. PM27575000
2. **Shumer DE**: Health Disparities Facing Transgender and Gender Nonconforming Youth Are Not Inevitable, 01/2018. PM29437859
3. Martin S, Sandberg ES, Shumer DE: Criminalization of Gender-Affirming Care - Interfering with Essential Treatment for Transgender Children and Adolescents, 01/2021

Erratum

1. Tishelman AC, Kaufman R, Edwards-Leeper L, Mandel FH, **Shumer DE**, Spack NP: Correction to Serving Transgender Youth: Challenges, Dilemmas, and Clinical Examples, [Professional Psychology: Research and Practice, 46(1), (2015) 37-45], *Professional Psychology: Research and Practice*.46(4): 249, 08/2015

Journal Articles

1. **Shumer DE**, Thaker V, Taylor GA, Wassner AJ: Severe hypercalcaemia due to subcutaneous fat necrosis: Presentation, management and complications, *Archives of Disease in Childhood: Fetal and Neonatal Edition*.99(5)01/2014. PM24907163
2. Tishelman AC, Kaufman R, Edwards-Leeper L, Mandel FH, **Shumer DE**, Spack NP: Serving transgender youth: Challenges, dilemmas, and clinical examples, *Professional Psychology: Research and Practice*.46(1): 37-45, 02/2015. PM26807001
3. Reisner SL, Vitters R, Leclerc M, Zaslow S, Wolfrum S, **Shumer DE**, Mimiaga MJ: Mental health of transgender youth in care at an adolescent Urban community health center: A matched retrospective cohort study, *Journal of Adolescent Health*.56(3): 274-279, 03/2015. PM25577670

4. **Shumer DE**, Tishelman AC: The Role of Assent in the Treatment of Transgender Adolescents, *International Journal of Transgenderism*.16(2): 97-102, 04/2015. PM27175107
5. **Shumer DE**, Roberts AL, Reisner SL, Lyall K, Austin SB: Brief Report: Autistic Traits in Mothers and Children Associated with Child's Gender Nonconformity, *Journal of Autism and Developmental Disorders*.45(5): 1489-1494, 05/2015. PM25358249
6. Tishelman AC, Kaufman R, Edwards-Leeper L, Mandel FH, **Shumer DE**, Spack NP: Reply to comment on "serving transgender youth: Challenges, dilemmas, and clinical examples" by Tishelman et al. (2015), *Professional Psychology: Research and Practice*.46(4): 307, 08/2015. PM26858509
7. **Shumer DE**, Reisner SL, Edwards-Leeper L, Tishelman A: Evaluation of Asperger Syndrome in Youth Presenting to a Gender Dysphoria Clinic, *LGBT Health*.3(5): 387-390, 10/2016. PM26651183
8. Tishelman AC, **Shumer DE**, Nahata L: Disorders of sex development: Pediatric psychology and the genital exam, *Journal of Pediatric Psychology*.42(5): 530-543, 01/2017. PM27098964
9. Edwards-Leeper L, **Shumer DE**, Feldman HA, Lash BR, Tishelman AC: Psychological profile of the first sample of transgender youth presenting for medical intervention in a U.S. pediatric gender center, *Psychology of Sexual Orientation and Gender Diversity*.4(3): 374-382, 01/2017
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Exhibit B
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